City of Torrance Community Services Department ● RECREATION SERVICES DIVISION
310/ 618-2930 ●WWW.Recreation.TorranceCA.Gov

# Participant Health Form/Medication Form

I. TO BE COMPLETED BY LICENSED PHYSICIAN

_____ _____ _____
Last Name First Name Sex School

Diagnosis/Purpose of Medication(s): _____
_____

_____

Name of medication(s): _____

_____

Dosage prescribed: _____

_____

Length of time medication will be necessary: _____
_____

Possible side effects: _____
_____

Action to be taken in case of side effects: _____
_____

Special instructions: _____
_____
_____

I verify that this student is under my care and requires this medication.

_____ _____ _____
Print Name Signature Date

_____ _____
Street Address City State Zip Code

_____
Telephone

II. TO BE COMPLETED BY PARENT/GUARDIAN

I request that my child _____, be given access to his/her medication at the requested time. If this request is granted, I agree to hold the City of Torrance Community Services Department harmless in providing this service to my child. I hereby give consent to the Community Services Department staff.
I _____hereby agree to the above stated contract.

_____ _____
Signature Date

"Creating and Enriching Community through People, Programs and Partnerships"

## CENTRALLY STORED MEDICATION

| FACILITY NAME |
|---|
| SPECIALIST |
| SUPERVISOR |

**INSTRUCTIONS: Centrally stored medications shall be kept in a safe and locked place that is not accessible to any person(s) except authorized individuals. Medication records on each participant.**

| NAME (LAST ) ( FIRST) ( MIDDLE) | ADMISSION DATE | ATTENDING PHYSICIAN |
|---|---|---|
| | | |

| MEDICATION NAME | STRENGTH/ QUANTITY | INSTRUCTIONS CONTROL/CUSTODY | EXPIRATION DATE | DATE FILLED | DATE STORED | PRESCRIBING PHYSICIAN | PRESCRIPTION NUMBER | NO OF REFILLS | NAME OF PHARMACY |
|---|---|---|---|---|---|---|---|---|---|
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